Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $97,164.33, for dates of service 05/22/01 extending through 05/25/01.

   b. The request was received on 03/11/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. Response to a Request for Dispute Resolution dated 05/16/02
   b. UB-92 and Itemized Statement
   c. Invoices for Implantables
   d. Operative Reports
   e. TWCC–62 forms
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. There is no sign sheet found in the dispute packet. The response from the insurance carrier was received in the Division on 05/17/02. All of the information in the case file will be reviewed and a decision will be written accordingly.

III. PARTIES' POSITIONS

1. Requestor:

> In the Table of Disputed Services the provider indicates:
> "Provider herein contends and submits respectfully to the Commission that Carrier has failed to comply with the Stop-Loss Provision set forth and established by the Commission pursuant to TWCC Rule 134.401. The Auditable charges in our view have not reduced the herein submitted bill below $40K. Therefore qualifying it for a stop loss payment of 75% of herein submitted charges. Tot[sic] due $117,154.80 Amount Pd. - $50,679.00 Net due $66,475.80."

2. Respondent:

> "Total charges billed were $155,942.01 - $88,499.50 implantable charges = $67,442.51. The $67,442.51 x 75% = $50,581.88 + an additional $8,460.10 (Implant cost + 10%). Total reimbursement paid was $59,041.98.
>
> The formula used is in harmony with the TWCC Acute Care Inpatient Hospital Fee Guideline. Specifics are listed on page 23-second paragraph and on page 70 Section (4) A.i-ii. Additional supporting specifics are found in TWCC Rule 134.401 Section (4) A."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 05/22/01 and extending through 05/25/01.

2. The Provider billed the Carrier $156,206.36 for the dates of service 05/22/01 and extending through 05/25/01.

3. The Carrier made a total reimbursement of $59,042.03 for the dates of service 05/22/01 and extending through 05/25/01.

4. The amount left in dispute is $97,164.33 for the dates of service 05/22/01 and extending through 05/25/01.

5. The amount in dispute ($97,164.33) listed in the Table of Disputed services has not been reduced by the 75% stop-loss Rule Per Rule 134.401.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $156,206.36. Per Rule 134.401 (c)(6) (A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. Per the EOB, the Carrier deducted $8,460.10 for supply/implants. The Carrier denied "Hospital Services" and the implantables with the denial codes of "F- Reduced According to Fee Guideline, N-Not Documented. M-Reduced to Fair and Reasonable. T-270- NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICES/SUPPLY PLEASE SEE SPECIAL *NOTE* BELOW. IMPLANTS WILL BE REIMBURSED AT COST PLUS 10% ONCE CARRIER RECEIVES DOCUMENTATION SHOWING HOSPITAL COST. ALSO NEED VERIFICATION OF EXACT AMOUNT OF IMPLANTS USED FOR SURGERY. UB-92 STATES 37-OPERATIVE REPORT DOES NOT REFLECT HOW MANY UNITS USED. F-481 REIMBURSEMENT WAS CALCULATED USING THE STOP LOSS METHOD. T-Not According to Treatment Guidelines." In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, which is indicated in the Medical Fee Guideline since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the hospital. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

According to the Spine Treatment Guidelines 134.1001(g)(7)(D), surgery is appropriate at this level of care.

However, review of the evidence from both parties reveals a difference in the number of items billed at various amounts, the number of items in the invoices and the number of items documented on the operative reports. There is some correlation between the descriptions of items used in the operative report to the description of the item in the invoice. There is however, no description identifying the same item on the hospital's itemized statement that correlates the usual and customary charge. For this reason, it is difficult to apply the stop-loss methodology to determine proper reimbursement for the documented implantables. Consequently, the Medical Review Division **does not** recommend additional reimbursement for the charges in dispute.

The above Findings and Decision are hereby issued this 11th day of October 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb